Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENNIUM CHIROPRACTIC

Respondent Name
WAL MART ASSOCIATES INC

MFDR Tracking Number
M4-14-1435-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
JANUARY 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Functional Capacity Evaluations (FCEs), which have been denied, are actually REQUIRED, according to the ODG guidelines…The FCE test on 1/23/13 was used to determine the functional abilities of the patient while participating in a pre-authorized Chronic Pain Management program from 12/21/12 to 2/24/13…The FCE performed on 3/22/13 was used to test the progress from that pre-authorized Chronic Pain Management program which ranged from 1/29/13 to 3/30/13."

Amount in Dispute: $1,012.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2013	CPT Code 97750-FC (12 units) Functional Capacity Evaluation	$342.32	$0.00
March 22, 2013	CPT Code 97750-FC (16 units) Functional Capacity Evaluation	$669.98	$546.10
TOTAL		$1,012.30	$546.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W9-Unnecessary medical treatment based on peer review.

- 5077-Based on a peer review, payment denied because treatment(s)/service(s) is medically unreasonable/unnecessary. If you disagree with this decision, you may request a reconsideration. If the original decision is upheld, you may request an Independent Review in accordance with Texas DWC Act 413.031 and adopted rule §133.308 within 45 days of the denial. A request for Independent Review must be filed in the form and manner prescribed by TDI.
- W1-Workers compensation state fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- 5375-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 29, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does a medical necessity issue exist?
2. Is the requestor entitled to additional reimbursement for the functional capacity evaluations rendered on January 23, 2013 and March 22, 2013?

Findings

1. According to the explanation of benefits, (EOBs), the respondent denied reimbursement for the January 23, 2013 FCe based upon reason codes "W9" and "5077." A review of the reconsideration EOBs finds that the respondent did not maintain the denial and issued payment of $436.88; therefore, a medical necessity issue does not exist in this dispute.

2. 28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   According to the submitted explanation of benefits, the disputed FCE was denied payment because the testing exceeded the number of test or time allowed at 28 Texas Administrative Code §134.204(g). The respondent did not submit any documentation to support this denial reason.

   The requestor noted in the request for reconsideration that "The first FCE was used to document the necessity for the patient to be admitted into the Chronic Pain Management program." The requestor states in the position summary that "The FCE test on 1/23/13 was used to determine the functional abilities of the patient while participating in a pre-authorized Chronic Pain Management program from 12/21/12 to 2/24/13…The FCE performed on 3/22/13 was used to test the progress from that pre-authorized Chronic Pain Management program which ranged from 1/29/13 to 3/30/13." Therefore, the Division concludes that the second FCE was performed on January 23, 2013 and the final on March 22, 2013.

   CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact. The submitted documentation supports the billed service; however, per 28 Texas Administrative Code §134.204(g) only two hours are eligible for reimbursement for the January 23, 2013 FCE and three hours for the one performed on March 22, 2013.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the

established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061 in Irving, Texas. Per Medicare the provider is reimbursed using the locality of Dallas, Texas.

The Medicare Participating amount for code 97750 is $33.60/15 minutes.

Using the above formula, the Division finds the MAR is:

DATE	MAR	AMT PAID	AMT DUE
01/23/2013	$436.88	$436.88	$0.00
03/22/2013	$655.32	$109.22	$546.10

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $546.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $546.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/22/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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